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ABSTRACT

Mental health counselors who work with children realize that the family is in a position to support or sabotage counseling efforts. If an accurate discrimination can be made between competent and incompetent families, both can be better served. Sources of information about a family include anecdotal records, teacher reports, and interviews with the child. The best source, however, is a structured family interview in which family members are encouraged to talk with each other about the child's behavioral problems. Criteria for evaluating a family's competence include: (1) parental resources; (2) time frame of problem behavior; (3) boundary characteristics and patterns of communication; (4) hierarchy of authority; and (5) relationship with professional helpers. A family that has been assessed as competent is a good prospect for brief family interventions which strive to enable families to gain control of problematic behavior with minimal reliance on outside professionals. A counselor can help a competent family gain control in as few as three family conferences by working with family members to implement a plan, open lines of communication, and support the hierarchy of parental authority. This model was tried in a school setting with four elementary school guidance counselors trained in the use of the family assessment model and brief intervention techniques. Seventeen case studies provide tentative conclusions about the model. (NB)

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Identifying Families Who Benefit from Brief Interventions

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ABSTRACT

The success of the child's treatment depends on a family's ability to implement a therapeutic plan. This article describes criteria for evaluating family competence and brief counselor interventions.

Identifying Families Who Benefit from Brief Interventions

Mental health counselors are very much aware of the importance of including families in the task of helping children adjust to the demands of home and school. There is ample support for the position that professionals should intervene to help families manage maladaptive behavior in children (Golden, 1984; Nicoli, 1984; Palmo et al., 1984). The family is in a powerful position to support or sabotage our best efforts on a child's behalf.

The mental health counselor's time, energy, and expertise are regarded here as precious commodities that must be wisely distributed. If an accurate discrimination can be made between competent and incompetent families, both can be well served. Assessment is critical because the success of the child's treatment depends on a family's ability to implement a therapeutic plan consistently (Speer & Sachs, 1985). The purpose of this article, therefore, is to describe: (a) criteria for evaluating a family's competence and (b) brief counselor interventions.

Assessing Family Competence

Sources of information about a particular family include anecdotal records, teacher reports, and interviews with the child. However, the best source is a structured family interview. At such an interview, family members are encouraged to talk with each other about the child's behavioral problems. What could account for the child's problem? What solutions have

already been tried? What changes in the child's behavior are desired? What will happen if nothing changes? Who wants things to change the most? Responses to these probes can shed light on family dynamics.

What is the difference between a competent family, here defined as one with whom the counselor can work with productively in a few brief conferences, versus a family that may require long-term psychotherapy and/or a combination of social and legal interventions? It is proposed that the competent family will score "high marks" on each of these criteria: (a) Parental resources, (b) Time frame of problem behavior, (c) Boundary characteristics and patterns of communication, (d) Hierarchy of authority, and (e) Relationship with professional helpers. Each of these criteria may be described on a scale of "1" to "5" (see Table 1).

Insert Table 1 about here

Parental Resources

A relatively simple decision must be made: Can these parents provide for the child's basic needs? A strong marriage, a supportive extended family, and gainful employment are resources that enable parents to respond to their child's problematic behavior. On the other hand, the young, immature, single parent may have fewer resources at his or her disposal. Families in which there is a history of extreme poverty or alcoholism or

child abuse bring very limited resources to the complex task of managing childhood behavior problems.

Time Frame of Problem Behavior

Is the child's misbehavior of short or chronic duration? Consider two familiar diagnoses from the Diagnostic and Statistical Manual, Third Edition, commonly called the DSM-III (American Psychiatric Association, 1980). The DSM-III defines an Adjustment Disorder as, "...a maladaptive reaction to an identifiable psychosocial stressor, that occurs within three months of the onset of the stressor" (p. 299). In contrast, a Conduct Disorder is, "...a repetitive and persistent pattern of aggressive conduct in which the basic rights of others are violated" (p. 45). While these are individual diagnoses, they have implications for family functioning.

As seen above, the DSM-III refers to "psychosocial stressors". Typical stressors in a child's experience include such events as the birth of a sibling, marital discord, the death of a beloved pet animal, a move to a new school, or the onset of illness. Stress may provoke a variety of problematic behaviors including enuresis, disruptive classroom behavior, antagonistic peer relationships, or a decline in academic performance. The presenting problem is of little relevance in evaluating family competence. Without the perspective of many years of living, a child is prone to act out in bizarre ways that may be disproportionate to the actual cause. Of far greater significance is chronicity. The fact that an emotional problem

has existed for a long time tells us something important about the competence of the parents to manage the current crisis.

A parent's response such as, "She's always been a difficult child. I can't understand it for the life of me!", indicates a less favorable prognosis than, "I lost my job in October and its been hard on all of us. His grades have fallen sharply since then".

Boundary Characteristics and Patterns of Communication

Family systems theory is concerned with the boundaries that separate individuals from each other. Minuchin (1974) describes three types of boundaries that separate individuals in a family. The diffuse boundary fails to provide opportunity for individuation. Children in these enmeshed families may be denied privacy and be overprotected; their development in the area of autonomy is obstructed. The rigid boundary blocks communication and creates distance. This closed system is maintained by yelling, blaming, sarcasm or, more ominously, silence. The following interaction illustrates elements of both rigid and diffuse boundaries:

COUNSELOR (To child): Tell your parents how much spelling homework you would do next week to earn Saturday morning television privileges.

FATHER (Angrily interrupting, to counselor): She would have to change her entire attitude!

MOTHER: It seems to me that the teacher is the one who needs a change of attitude. It is ridiculous to expect a child to do an

hour of homework after being in school all day long.

With his critical response, the father in this exchange ensures that a meaningful dialogue with his daughter will be avoided. The mother reinforces her daughter's dependency by speaking on her behalf against the teacher.

The permeable boundary allows for both healthy individuation and deep interpersonal involvement. The permeable boundary is, of course, characteristic of relationships in competent families. Boundary characteristics are evident in the ebb and flow of communication. If family members cannot talk to each other, they may not be able to help one another.

Hierarchy of Authority

It is useful to imagine an organizational chart that illustrates family structure. Parents in competent families hold an executive decision making position within the family organization. This is not to say that children do not have age-appropriate opportunities for having their opinions heard and respected. In incompetent families, however, children have undue power because of parental default. Children in such families appear out of control and their parents seem helpless.

Parents who are successful in asserting authority are likely to agree on basic principles of child rearing that help them to "hang tough" when confronted with a child's manipulations. When the hierarchy of authority is disturbed, parents will be unable to agree on effective measures of control.

Relationship with Professional Helpers

Can these parents and school or agency professionals work as an effective team? Dependability is central to the issue. Do these parents return phone calls? Do they show up for conferences? The real test, however, is follow-through; the competent family does its "homework". For example, there may be an agreement that the parent will help the child with an assignment at home and telephone the teacher on the following day to make sure the assignment was submitted. There is a good probability that a competent parent will complete these tasks, whereas the incompetent one will fail for any number of reasons.

At the risk of over-generalizing, it is claimed here that counselors tend to be verbally and psychologically sophisticated and establish rapport most easily with parents who "speak the language". Parents who feel intimidated by professionals will need special encouragement. Hostile, litigious parents may be almost impossible to work with because school and agency authorities will feel pushed into a defensive stance. Positive energy is drained by the need for meticulous documentation.

A Single Case Illustration

The following case, (contributed by Laurie Griepenkerl, a counselor at Woodstone Elementary School in San Antonio, Texas,) serves to illustrate the assessment model.

Bryan R., age 7, was referred by his father who reported behavior problems that began three months before when his wife took a job as a secretary, the first time she had left the home

to work. Mr. R. was a sales representative with evening hours and had ample time to confer with the school counselor. Mr. R. reported that Bryan had always been a model child at home and school. He was enrolled in classes for the gifted and talented. An older brother, Steven, age 9, was also gifted. Mr. R. said that both sons had previously responded with alacrity to parental wishes. Conflicts were resolved through rational family discussions. These procedures continued to work with Steven but had become ineffectual with Bryan. For example, Bryan shirked his chores and embarrassed his parents by "talking back" in public places.

Bryan disclosed that he felt approved of in the family as long as he followed in Steven's footsteps. For example, he was encouraged to play the violin as did his brother. Bryan complied even though he really wanted to learn karate. Steven was a "loner" who avoided socializing with peers, preferring family relationships. Bryan insisted on playing with friends outside the home. His mother told him that she was afraid he would be kidnapped. Bryan said that his classmates teased him because his father walked him to and from school. He also expressed anger at his mother's decision to go to work.

In conference with the school counselor, Mr. R. decided to provide consequences for performance or nonperformance of chores and to allow Bryan more independence. Bryan would be permitted to walk to school in the company of his older brother. His father would arrange for Bryan to play with an "approved" friend.

Counselor impressions of this "ideal" family began to shift as it became obvious that they would not carry out the plan. With further contact, Mr. R. emerged as an autocratic decision maker; Mrs. R. was described by her husband as desperately dependent. She had been hospitalized on two occasions with a nervous disorder and suffered from a variety of stress related problems, including asthma and ulcers. Steven had developed asthma and a facial tic. The family was close knit; the atmosphere was smothering.

The prognosis for change was poor as the family clung to its historical "image" in lieu of taking risks. However, Mr. R. was eager to continue counseling conferences indefinitely. The school counselor referred for family therapy and declined contacts until follow-through was demonstrated.

With reference to the assessment criteria, it appears that the R. family was a poor candidate for brief interventions. The family's level of competence is described here on a scale of "1" (Very Negative) to "5" (Very Positive) for each criteria.

Parental resources. Score: "2". These parents possessed sufficient material resources. However, coping skills were poor, as illustrated by Mrs. R.'s history of psychosomatic and nervous disorders.

Time frame of problem behavior. Score: "5". Bryan's misbehavior was reported as a recent problem.

Boundary characteristics and patterns of communication. Score: "1". Parental reluctance to encourage outside friendships

and otherwise support independence would suggest that normal individuation was being obstructed. Information about parental communication was minimal since the mother did not attend the conferences.

Hierarchy of authority. Score: "2". The formal lines of authority were clear: Mr. R. was the Boss! However, the parents' power was eroded by their fear of change. The only safe course for this fragile structure was rigid adherence to the status quo.

Relationship with professional helpers. Score: "2". Initially, the counselor was impressed with Mr. R.'s desire to cooperate. With time, however, he came to be regarded as a nuisance by the school's staff. Mrs. R. did not attend any conferences.

Brief Family Interventions with Competent Families

A family that has been assessed as competent is a good prospect for brief family interventions. The goal is to enable families to gain control of problematic behavior with only minimal reliance on an outside professional. These kinds of interventions are especially appropriate for school or agency counselors, professionals who must weigh the extent of their commitment to a particular case against the demands of a large client population.

The strategy comprises a team effort to shape up a child's behavior. It is proposed that a counselor can help a competent family gain control of childhood misbehavior in as few as three face-to-face family conferences (Golden, 1983; Golden, 1984).

Failure is indicated when there are more than six family conferences without resolution of the problem. It is likely that individual or family therapy would be the treatment of choice. Note that contacts with the family are termed as "conferences", not "sessions", because of the therapeutic associations of the latter term. It is important to clarify to the family that it does not need nor will it receive "therapy" from the mental health professional.

This process is best described by a literal example of what might be said to a family. In this case, the child presents a problem of intermittent truancy:

> I am interested in working with your family for a limited period of time to help you get this problem straightened out. I think you can manage this situation with only a minimum of help from me but if it develops that there is a need for another type of approach, I will bring that to your attention. There is cause for optimism. Your son has a previous record of good attendance prior to his truancy this year. As parents, you have shown that you are willing to work with your son to get this problem resolved. My goal will be to help you, as parents, in your efforts to get your son to go to school every day. We won't talk about past grievances; we will focus on the present problem.

Implement a plan. According to Haley (1980), parents must agree on three issues if they are to work together to manage

their child's behavior: (a) the specific behaviors that are desired from the child (b) the mechanism by which the parents will know if their child has behaved in the desired way, and (c) the specific consequences for behavior or misbehavior. It is essential that both parents agree on each of these points. If marital discord surfaces, parents should be encouraged to work toward agreement for the good of their child and deal with their marital problems at some later time.

In most cases, the "plan" will consist of the teacher sending home daily reports about the child's behavior followed by parental reinforcement of positive performance. For example, the teacher may write that the child remained in his seat during the arithmetic lesson. The parents then permit the child to color one spot on a picture of a giraffe. Eventually, when all the spots are colored, the child has earned a trip to the zoo.

The family is encouraged to brainstorm about ways a plan could be sabotaged. For example, the child could "lose" the teacher's report and cause the plan to break down for lack of communication. The child could threaten to run away or commit suicide and thereby panic his parents into surrender. The plan is treated as an "experiment" so that the family can more easily accept the risk of failure.

Meanwhile, the counselor attempts to build an influential relationship with the child in order to reinforce goal behavior. The counselor must convince the child that he or she cares. To that end, home visits and classroom observations can be useful.

A telephone call or a postcard from the counselor can be very special reinforcers for some children.

Open lines of communication. According to Satir (1972), there is a tendency to close down communication during periods of stress. Frightened, anxious people tend to blame, withdraw, or to adopt any strategy that will diminish the experience of painful realities. Unfortunately, it is precisely during these periods of stress that open communication is most crucial. At the start, the counselor should challenge the family's feelings of helplessness. Leavitt (1982) advises prompting to recall the family's resourcefulness in handling stressful situations in the past.

In a competent family, a gentle and respectful application of basic, active listening skills (e.g., paraphrasing, reflection) will usuallly suffice to get people talking. These facilitative skills have been discussed in the professional literature, notably by Brammer (1979), Carkhuff (1969), and Rogers 1980), and therefore are not presented here.

Support the hierarchy of parental authority. In stressful times, even competent parents are quick to relinquish authority to outside professionals. Haley (1980) emphasizes the importance of putting parents in charge of managing the child's behavior problems. The distressed child is making a plea, albeit indirect, for parental control. Out of feelings of guilt and confusion, parents may permit the child more freedom than is approporiate.

Encourage parents to take control of resources that could serve as reinforcers. For example, an adolescent who is "independently wealthy", sporting a big allowance and a room full of electronic equipment, is in a position to "blow off" her parents' demands for behavioral change. In this case, the child's allowance could be eliminated entirely. She earns money by behaving responsibly.

The artistry in this approach lies in supporting the authority of the parents without alienating the child. It helps to reframe the child's apparently negative motives and hold out hope for the future. For example, here is a counselor response to fifteen year old Cindy who has attempted to run away from home only to "crawl" back, unable to support herself: "Cindy, the most important job you have to do is making a plan for leaving home on your own two feet. How much money do you need to get started on your own? What will it take to earn your own living (education, skills, references, transportation)? How can your parents help you prepare?" The process of preparation for this crucial life task can be ego-enhancing for both parent and adolescent (Haley, 1980).

Implications of Seventeen Case Studies

In order to test the practical implications of this model, it was tried in a school setting. The participants were four elementary school guidance counselors. These counselors were trained in the use of the family assessment model and brief interventions techniques. Subsequently, they received five group

supervisory sessions while they worked with families.

Children were referred either by teachers or parents and were part of each counselor's normal case load. Families who were invited to participate were described by counselors as being "competent" according to the specified criteria. Referrals ranged in age from six to twelve and were evenly distributed across elementary grades. "Brief Family Interventions" were defined as cases in which counselors had at least three face-to-face contacts with a parent. Three counselors reported four cases each and one reported five for a total of seventeen cases.

It should be noted that the case study method employed has the limitation that it does not yield conclusive data (Barlow & Herson, 1984). However, the carefully constructed case study can yield descriptive data that sheds light on a clinical phenomenon (Barlow & Herson, 1984). These seventeen case studies of "brief family interventions" support some tentative but interesting conclusions.

A. School counselors should give themselves permission to decide which cases to work with and which to refer. The data support the view that the more competent a family is to start with, the less of the counselor's time will be consumed and the more positive the final outcome will be. Counselors who misdiagnose and attempt to organize a highly dyscompetent family have let themselves in for frustration. In fact, such a family is effectively organized against the threat of change.

B. It is important to determine if the hierarchy of parental authority is intact. The data support the view that firmly established parental authority contributes more to behavioral change than good communication in the family, problem solving skills, or short duration of problem behavior.

C. With reference to the assessment instrument's scale, with "1" describing the negative and "5" the positive extremes, the results show that counselors are unlikely to encounter level "5" families in their practice. Whether employed in schools, agencies, or in independent practice, mental health counselors may find themselves overwhelmed with dysfunctional families. The pleasure of working with a highly competent family, on the other hand, may be a rare experience. Based on this reality, the author has come to define incompetent families as those who have a mean assessment of "1" or "2"; reasonably competent families, those that average "3" or above.

D. Counselors should expect to spend about four and one half hours on a "brief family intervention" with a competent family.

E. There is a sequence of counselor interventions that seems to be effective - (1) Include parents, teachers, and the child in devising a plan that specifies goal behaviors and consequences; (2) Encourage parents to follow through with consequences; (3) Encourage the child to try adaptive behaviors; (4) Phase out the plan with intermittent reinforcement.

F. Brief family interventions can work with single-parent

families as well as with the traditional nuclear family. The process can be crippled, however, if one of the parents the child normally lives with is absent from the conferences. This is more significant if the parent's absence reflects disinterest or opposition than a bona fide difficulty with scheduling.

G. Taking a "wait and see" instead of a "go for it" attitude is probably a mistake. Since school personnel can be overwhelmed by the demands of their work, there may be a tendency to opt for "a little bit of this, a little bit of that", and then to give up when positive gains prove elusive. As one counselor stated rather poetically, "The counselor gave up on the parents, the parents gave up on the teacher, the teacher gave up on the student, the student gave up!"

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TABLE 1

Assessment of Family Competence

Respond on a scale of "1" [Very Negative] to "5" [Very Positive]:

[ ] Parental resources
Can parents provide for the child's basic needs?

[ ] Time frame of problem behavior
Is the child's misbehavior of short versus chronic duration?

[ ] Boundary Characteristics and patterns of communication
Is communication between family members clear and open?

[ ] Hierarchy of authority
Are parents effective in asserting authority?

[ ] Relationship with professional helpers
Can parents work cooperatively with school or agency staff?